Gary W. Nelson, MD*
Dylan R. Wells, MD*, FACOG
Mary D. Wells, MD*, FACOG
Leslie L. Evans, MD*, FACOG
Megan B. Dimoff, MD*, FACOG
Alison A. Hollis, D.O.

FAIRHOPE

GYNECOLOGY & OBSTETRICS

19450 South Greeno Road
Fairhope, AL 36532
251-928-1222
FAX 251-928-2398
www.fairhopeobgyn.com
*Diplomates of American Board of Obstetrics & Gynecology

Chart Number ____________________ Date ____________________

Patient Name

____

Last First Middle Maiden

Mailing Address

______________________________City/State/Zip______________________

Street Address

______________________________City/State/Zip______________________

Home phone # ______________Cell phone # ______________ Work # ______________

Birth Date ______________ Age ____ SSN ______________________

Marital Status: S M D W Separated Ethnicity ______________________

Email Address:

____

Patient Employer

____

Emergency Contact ______________________ Relationship ________ Phone# __________

PLEASE PRESENT A COPY OF YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE TO RECEPTIONIST

Primary Insurance Company: ____________ Secondary Insurance Company: ______________

RESPONSIBLE PARTY (person, other than patient, who has the insurance)

Name ____________________Birth Date ____________ Phone #____________________

Mailing Address ____

Employer ______________________________Work # ______________________

I understand there may be certain services that are necessary for the maintenance of my good health that are not covered by my insurance, and I agree to pay for those services in full. I hereby authorize my insurance benefits to be paid directly to the physician. I also authorize the physician to release information required in the processing of any claim. In instances where I have been referred to another physician or medical facility, I hereby give my permission to fax or mail pertinent medical information for continuity of my care. I have read the above policies and agree to pay for services not covered by my insurance. I also agree to pay reasonable attorney's fees and cost of collection if this matter is referred to an attorney.

Signature ______________________________________ Date ______________

Responsible Party Signature ______________________________________

Let us reassure you that we will only order tests that are necessary for your treatment and care. If you have any questions, someone in our office will be happy to assist you. Thank you very much for your understanding.

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Payment Policy

All payments are due at the time of service. This is a contractual agreement between you and your insurance carrier; we are not allowed to dismiss it. In the event that you cannot pay your co-payment at the time of service, we will add an additional $15 to cover the cost of billing and collection.

Late Arrival Policy

Please notify the office as soon as possible if you are running late for your appointment.

If you arrive late but less than 30 minutes late, you will be worked into the schedule according to arrival time, if the schedule permits. If you arrive 30 minutes after your appointment time your appointment will be rescheduled. Extenuating circumstances may allow you to be worked into the scheduled, at our discretion, if the schedule allows.

Due to high volume of ultrasounds; if you are late for an ultrasound appointment, you may be asked to reschedule your appointment. We may work you in if the schedule allows however, be prepared to wait for up to two hours.

No Show Policy

As a courtesy to our patients we have an automated reminder system. Regardless of whether or not a reminder was received, it is your responsibility to call and cancel your appointment if you are unable to keep it. Please give a 24 hours' notice if you are unable to keep your appointment.

Laboratory Policy

Fairhope Gynecology and Obstetrics uses Quest Diagnostics lab as an in-office laboratory. Please review your insurance coverage to determine if Quest is in-network with your plan.

Your physician may recommend labs; this does not guarantee they are covered by insurance. You will receive a separate bill from Quest for these services.

These policies are designed in minimize waiting time and improve patient satisfaction. We appreciate your understanding, as indicated by your signature below.

Patient Signature____ Date____________________

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Permission to Release Information

From time to time our doctors and staff are unable to reach a patient directly concerning lab results, pathology reports or medical information. It is at the patient's discretion when and with whom we may share this information. This is due to HIPAA (Health Information Portability and Accountability Act) of 1996.

Your signature below indicates that this consent extends, indefinitely, from the date on this form until or unless changed by you in writing.

I authorize Fairhope Gynecology and Obstetrics to release information concerning me to whom I have listed below (please check appropriately):

_____Myself Only   ______ My Answering Machine   ______ Myself and /or those listed Below

1. Full Name ______________________________
   Relationship ______________________________
   Phone #______________________________

2. Full Name ______________________________
   Relationship ______________________________
   Phone #______________________________

3. Full Name ______________________________
   Relationship ______________________________
   Phone #______________________________

Printed Name______________________________ Chart # ______________

Patient (14 or older) Signature______________________ Date ______________

Witness______________________________ Date ______________

FAIRHOPE
GYNECOLOGY & OBSTETRICS

Protective Services for the President and Others: We may disclose health information to authorized federal officials so they may provide protection to the President, other authorized or foreign heads or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correction institution or under custody of a law enforcement official, we may release health information to the correctional facility or law official. This release would be necessary: (1) foe the institution to provide you w with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional facility.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care o Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to the at person's involvement in your care. If you are unable to agree or object to such discloser, we may disclose such information as necessary if we determine it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose you Protected Health Information to disaster relief organizations that seek your Protect Health Information to coordinate your care, to notify your family and friends your location or case of a disaster. We will provide you with an opportunity to agree or object to such discloser whenever we can practically do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURE

The following uses and disclosures of your Protected Health Information will be made only with your written authorization: Uses and disclosure of your Protected Health Information for marketing purposes; and Disclosures that constitute the sale of your Protected Health Information. Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose your Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have the right to inspect and copy your Protected Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy your Protected Health Information, you must make your request, in writing, to the office manager. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you're a fee if you need the information for a claim for benefits under the Social Security Act or any other federal needs-based program. We may deny your request in certain limited circumstances. If we deny your request, you have a right to have the denial reviewed by a licensed healthcare professional that was not involved in the denial of your request and we will comply with the outcome of your review.

Right to an Electronic Copy of Electronic Medical Records: If your Protected Health Information is maintained in a electronic format (known as an electronic health record or an electronic medical record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If your Protected Health Information is not available in the requested form or format, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electric health information.

Right to Get Notice of a Breach: You have the right to be notified of any breach of your Protected Health Information.

Right to Amend: If you feel that your Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. To request amendment, you must make your request in writing, to the office manager.

Right to an Accounting if Disclosures: You have the right to request certain disclosure we have made of your Protected Health Information for purposes other than treatment, payment and healthcare operation or for which you provided written authorizations. To request an accounting of disclosure, you must make your request, in writing, to the office manager.

Right to Request Restrictions: You have the right to request a restriction or limitation on your Protected Health Information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on your Protected Health Information we disclose to someone in your care or the payment of your care, like a family member or friend. For example, you could ask that we not disclose to someone involved in your care or treatment with your spouse. To request a restriction, you must make a request, in writing, to the office manager. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of- pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket Payments: If you paid out-of-pocket(requested not to bill your health plan) in fill for a specific item or service, you have the right to ask the your Protected Health Information, with respect to that item or service, not be disclosed to your health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can ask that we only contact you by mail or at work. To request confidential communications, you must submit your request, in writing, to the office manager. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask to give us a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.fairhopeobgyn.com. To obtain a paper copy of this notice, ask the receptionist.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to your Protected Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the office manager. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

Effective 12/13/18

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED/DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

OUR OBLIGATIONS: We are required by law to; maintain the privacy of protect health information; give you this notice of our legal duties and privacy practices regarding health information about you; follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may use and disclose health information that identifies you ("the patient"). Except for the purposes described below, we will use and disclose health information only with your written permission. You may revoke such permission at any time by completing a new "release of information" form.

For treatment: We may use and disclose health information for your treatment and to provide you with treatment related health care services. For example, we may disclose health information to doctors, nurses, technicians, or other personnel, including people outside of our office who are involved in your medical care.

For Payment: We may use and disclose health information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment of services you receive. For example, we may give your health plan information about you so that they will pay for your treatment.

For health care operations: We may use and disclose health information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure that obstetrical and gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example: your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits Services: We may use and disclose health information to contact you to remind you that you have an appointment with us. We also may use and disclose health information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals involved in your car or payment for your care: When appropriate, we may share health information with a person who is involved in your medical care or payment for your care, such as your family or close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose health information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to health them identify patient who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any health information.

SPECIAL SITUATIONS:

As required by law: We will disclose health information when required to do so by international, federal, state, or local law.

To avert a serious threat to health or safety: We may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other that as specified in our contract.

Organ and Tissue donation: If you are an organ donor, we may use or release health information to organizations that handle organ procurement or other entities engaged in procurement and banking or transportation of organs.

Military and Veterans: If you are a member of the armed forces, we may release health information as required by military command authorities. We also may release health information to the appropriate foreign military.

Workers' Compensation: We may release health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability, report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required by law.

Health oversight activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data breech notification purposes: We may use or disclose your health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and disputes: If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We also may disclose health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law enforcement: We may release health information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premise; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, medical examiners and funeral directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors as necessary for their duties.

National security and intelligence activities: We may release health information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

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Due to frequent changes in insurance policies, it is difficult to determine coverage for each individual policy. Although we try to stary aware of changes, it is not always possible.

Therefore, we encourage you to check with your insurance company prior to any testing or procedures. **It is your responsibility to know individual coverage**. Failing to follow recommendations could result in you, the patient, being responsible for the cost incurred.

Please remember your insurance contract is between you and your insurance company, **NOT** your insurance company and the physician.

Signature ______________________________ Date ________________________

Witness Signature _______________________

HIPAA

I acknowledge receipt of the privacy notice from Fairhope Gynecology and Obstetrics.

Signature ______________________________

Print Name _____________________________

Date __________________________________